Clinical Quality Workgroup
Draft Transcript
April 23, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Thank you. Good morning, everybody, and welcome to the Clinical Quality Workgroup. This is a federal advisory committee. There will be opportunity at the close of the meeting for the public to make comment. Let me do a roll call of the workgroup members. Janet Corrigan?

Janet Corrigan – National Quality Forum – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Floyd Eisenberg?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
John Derr?

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Doug Fridsma? Judy Murphy is traveling. She's not on the call. Marc Overhage? Rick Stephens? Jim Walker?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Walter Suarez?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jodi Daniel? Carol Bean? Jack Corley? Ken Gebhart? John Halamka? Did I leave anybody off? Okay. With that, I'll turn it over to Janet.

Janet Corrigan – National Quality Forum – President & CEO
Great. Thank you very much, Judy. Appreciate it, and thanks to the workgroup members for joining in the call today. We wanted to spend a little bit of time, once again, thinking about our next steps in terms of identifying potential measures that might be used for 2013. And the challenge that we have here is that we have limited time to be able to actually generate these measures.

We have a limited timeframe here to be able to identify measures for 2013 because it takes a significant amount of time to move measures through the development, the testing, the endorsement phases, and then actually getting the e-specifications in a standardized format. So we thought one of the potential solutions here, which we discussed on our last call, was that we might identify e-measures that already exist and have been well tested, at least within one healthcare setting, by going out and identifying systems that have had electronic health records and personal health records for a number of years and, consequently, have really started to measure quality and performance overall using their health information technology, and that those would be likely settings that could potentially could perhaps tap into in identifying measures that are already developed.

I want to be a little bit cautious here because I think it's very, very important to kind of manage expectations. Even though measures may have been developed and used within one particular setting, they still, in order to be able to become national standardized measures with specifications that build off of the quality data set and link to the PHR standards that the standards committee has recommended, have to go through a fairly lengthy process. But at least they would have then developed and have had a degree of localized testing.

What we wanted to discuss today was an approach of potentially doing what we're calling a limited environmental scan, and this would be to reach out to a limited number of healthcare settings and essentially ask respondents for three things. First, to share with us the e-measures that they currently use within their health system, and we'd really only be interested in the e-measures that were not included in the NPRM list, so they're not ones that have already. There's a similar measure that's been nationally endorsed and that has been included in the NPRM. We're not interested in those, but rather there are other measures, other kinds of things that they're measuring.

Then, second, we thought it might be good to ask them, based on their experience and knowledge, what is that subset of measures for which HIT tools, whether that's clinical decision support, checklists, perhaps reminders were particularly important in facilitating rapid improvement because it would be nice if we had some measures in the meaningful use for 2013 that take advantage of the capabilities of HIT to yield real measurable improvements in better healthcare and better health for patients.

Then, third, and I think this followed up on a comment that Jim Walker made at our last conference call was that we'd also like to identify that subset of measures where HIT alone isn't going to be adequate to facilitate better performance. There really needs to be significant workflow or care process redesign, and that, in many ways, would then really raise the bar in terms of what has to be done to accomplish and demonstrate meaningful use of the technology.

This is basically the list of organizations that are represented on the standards committee at this point. Since we really don't need to go out to the whole universe, this is more of a limited environmental scan, as I indicated. We wanted to get some feedback, not only on the approach, but on this set of organizations that really do cover many, many different settings, geographic settings, as well as organized delivery systems, some being very tightly wired, and others being more loosely structured and having small practice settings in them. In addition to that, you might want to also reach out to Veterans Health Affairs or Indian Health Service on the federal side, both of which have had that extensive use in this area.

Let me stop there for a minute and solicit input and discussion, and I'll back up here on the slides to the three questions that we were proposing might be useful to ask those respondents in this limited environmental scan.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Janet, this is John Derr. Is there an assumption, which I hope there is, that by 2013 that long-term post-acute care might be part of this whole thing and, therefore, maybe we want to get, for number ten, somebody from that that has services in all the different sectors of LT PAC and start working on assumption that we will be in meaningful use by 2013, which it seems like there's a paper coming out this summer that's going to add more people to the meaningful use and that we, as a group, would assume that nursing homes and homecare would be part of it.

Janet Corrigan – National Quality Forum – President & CEO
Yes. What does the group think? I don't have any trouble with that. I think it would be a very good thing, as you know, John, to get the long-term care settings involved. Many of these measures that potentially would be included are going to cross the settings, so whether they're preventative service measures or treatment for asthma or diabetes, people in long-term care settings also have those conditions. So it certainly would seem like a compelling reason to think about having some long-term care representation.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
It's like you and I talked before. If we're looking at a person centric, longitudinal, integrated, clinical record, you've got to have the same quality measures across the different care settings, or there'll be confusion when one moves from one to another.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
This is Jim Walker. I totally agree. The only question is logistics. We've got to get all of the healthcare team integrated into these measures and processes.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
I mean, I am going to see Floyd, which I appreciate, next Wednesday afternoon to try to start working on things in the background again for retooling, even right now. But I was on a call yesterday where there's a whole other set of quality measures that are being designed from CMS, and they're not in harmony with what we're doing. And it just seems somebody's got to start looking at a 50,000-foot level or it's going to get very confusing, at least for our sector.

Janet Corrigan – National Quality Forum – President & CEO
Yes. It is a challenge, given that, as I understand that the assumptions about the underlying data that will be available electronically for long-term care settings are quite different, given the historical legacy of NDS and Oasis. You know that better than I do, John, so I think, Jim, you're right. It's an issue of logistics and what we can potentially take on.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
I even heard yesterday that, with all due respect to CMS, that they're developing a discharge program based on MDS-30 and also on CARE and, of course, and Oasis. And I asked if they'd been talking about the CCD or anything like that, and they said no. And of course, MDS-3 and Oasis are not in the CRA type architecture where CARE is – too many acronyms. But that really disturbed me that they're not looking at the CCD when we, over here, on our committees are looking. Well, right now, CCD and CCR, but hopefully the CCD will be the survivor discharge program, and quality measures should be in there, and they should all be the same, and not reinvent different wheels. Sorry I talk too much.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think we all agree with you, John.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
I know you guys do.

Janet Corrigan – National Quality Forum – President & CEO
Yes. No, we do. We do agree with you. That's the challenge here, but so I guess we could potentially, certainly could add an additional number ten that would be a long-term care setting.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
And I'll volunteer Golden, which we have all the different pieces, but I have to check with management to make sure. But I'll find somebody or maybe in partnership with somebody else, but that we can be part of all the rest of the group there.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Janet, this is Jim. I have a slightly different perspective. Vendors, at least some of the vendors have shared libraries of these things. Since we have Epic concern, I'm not sure who all else represented on policy and standards. It might be an efficient way to capture really a fairly wide environmental scan pretty efficiently, and it might be too much trouble to try to do.

Janet Corrigan – National Quality Forum – President & CEO
Basically, reach out to Epic and Cerner, and which vendors beyond that would we need to reach out to cover the majority of this?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think NexGen and GE and probably e-ClinicalWorks captures a very large portion of the sort of small practice. I assume this is limited, this is quick, and so we just give everybody same amount of time to respond. And if they do, then we have the data. And if not, we don't worry about it.

Janet Corrigan – National Quality Forum – President & CEO
That's a good idea. That's a great idea. Well, before we move away from that, what do you think of the questions that are here? Are these the right questions on the slide to identify they measures they use, not in the NPRM where that's going to yield a fairly long set of measures, but then to really seek their input on which ones use the HIT tools most and which ones require a workflow redesign?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think that's a very good structure. We might add something, but I'm not sure what it is. I think that will help us isolate the things that make the most sense to focus on soonest.

Janet Corrigan – National Quality Forum – President & CEO
Okay. And my greatest concern is that we're going to be a bit overwhelmed with very, very long lists. We'll have to try to kind of move through them, at least with number two and number three, if we ask them to be more limited and say, identify five measures that you think HIT tools contributed most to deliver the greatest potential using HIT tools. The five measures were significant. No more than five, I think, just to limit it a little bit more.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Tactically, we might leave one out in this first phase. We might just say, "Look, tell us the ones that HIT by itself was a pretty important part of achieving pretty significant movement," and then maybe we come back to them later and try to capture the whole universe because I think there could be virtue in that, but that you're right. That's a whole lot bigger task, and maybe we could just let them do the filter for us at the beginning.

Janet Corrigan – National Quality Forum – President & CEO
Yes. That makes a lot of sense, actually. I like that idea a great deal because the other could be a bit overwhelming. So we'll just deal with the second two. Good idea. Okay.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes. And what we might do, actually, on number two, if we said identify the ones that, blah blah blah. And we might say, "In your experience, which were the highest impact, medium impact, low impact?" Then if they want to give us 30 each, it still wouldn't overwhelm us. We could just say, okay, first pass. We're just going to look at the ones that they thought were the highest impact, and we'll come back maybe and do the others later.

Janet Corrigan – National Quality Forum – President & CEO
Right. All right. That's a good suggestion. Sounds good. Great. John, are you comfortable with the questions in that approach?

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Yes, I am.

Janet Corrigan – National Quality Forum – President & CEO
Great. So then I guess the next thing would be then our list, we've agreed. John is going to see whether or not we can go ahead and add Golden to this list. What do you think about also adding the Veterans Health Affairs and Indian Health Service?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think that makes sense.

Janet Corrigan – National Quality Forum – President & CEO
All right. And next, before you came on, Judy and I were chatting a little bit, and she had a great suggestion was that once we get this information in, and we synthesize it, so we perhaps have a master list of the measures that had the greatest potential to make improvement using HIT tools, that we could then put that out on the blog and get some public comments, which could be a way to, while still keeping the environmental scan limited initially, we would undoubtedly get some other comments that come in probably, and additional suggestions, and would be a little bit broader than the set that we actually go to.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Sure. And I think, in all our communications, we ought to emphasize to people that we're trying to do some fast, high impact for 2013. But we absolutely want all their input because we need to come back then and do a more thoughtful approach for 2015, 2017, and 2019. And I think everyone will appreciate that. And then we won't get so much of why isn't this in, and why aren't we included sort of thing.

Janet Corrigan – National Quality Forum – President & CEO
All right. We thought it might be helpful. John Halamka was kind enough to share the BI Deaconess measures, and he was comfortable with our going ahead and sharing them broadly, and even identifying the institutions. Floyd, do you want to speak to this list a little bit? You've had a chance to take a look at it. This one isn't filtered according to high impact measures. This is just the full list, essentially, of measures that they use that were not included in the NPRM. We have taken those out.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right, and I do apologize for the size of the print on the screen. I didn't realize it would look quite that small. The members of the committee do have the presentation. What was provided to us, and John's group was very gracious to do that, was a list of measures that they currently use because of contract incentives. And that's the first list. They also provided which of the NPRM list they're working on, but that was, as Janet said, not something that we really need to address because they're already addressed.

They also provided to us a list of custom measures, and that's later in the slides. But if I go through this, basically we did a very quick review to see if some of the measures they were performing because of their contracts were in or similar to an endorsed measure already in existence. And if there is one, I listed in red and in bold what the related endorse measure is, so to see what's there and what might be needed and isn't there. So, as we look through this list, some of the examples are there. I won't go through all the detail on these, but some of these were on A1c testing, but looking for two A1cs for diabetics every year, which is a measure currently endorsed, so in the first slide, you see all the endorsed ones.

I guess I can move it to the second, where again, I apologize for the size of the slide. But you'll see on here, there are some that, for their contract measurement requirements, there were some modifications, mostly at change in the age and the level of LDL control for number 11 on here. So slight modifications to what is endorsed, which is why it says parcel and an addition of other conditions that the original measure didn't deal with, so some of their contracts deal with some additional elements. Most of them are fairly close to existing measures.

I have them all listed here, going through, but most of these are fairly close to what's existing. There are a few additional ones about well child visits during third, fourth, fifth, and sixth year, a few concerning some minor changes. But most of the ones related to contracts, similar to the NPRM, are already endorsed measures. The new information is really related to the custom measures, so there are measures out there they're reporting for public reporting. But these are measures they use internally to determine performance in their own provider base.

Again, some of these are similar to existing measures, but more detail, so the current measures for lipid screening are for those with diabetes or those with ischemic vascular disease. So what they've done is they've expanded to all male patients greater than 35, female greater than 45, who don't have ischemic vascular disease or diabetes. So they're looking at the rest of the population. The same for, is lipid screening done and are they under control; the same for patients on aspirin or other antithrombotic.

Influenza vaccine looks at the younger age group, whereas most measures look at the older age group. They're looking at 18 to 49 as well with an annual flu shot, also children and other high-risk children 5 to 17. Lead testing, appropriate antibiotics with asthma is close to an existing measure. So basically what this is most of these are modifications of existing measures to expand populations.

Now I did hear from another organization about some other process measurers that are somewhat deeper. If you want to have discussion on what's on the slides first before I get to the other one, I'm happy to do that.

Janet Corrigan – National Quality Forum – President & CEO

Sure. Yes. Let's have some discussion. It strikes me, as I look at these measures. And, Jim, you're closer to this than I am, certainly, and I would like to get your input. But it strikes me. The ones that probably do meet that criteria of requiring workflow redesign to accomplish, I assume, would be things like number 29 on the contract incentive list, which is the well child visits in the first 15 months of life, if it was structured to basically sort of only give credit for having all of the appropriate number, 6 or more.

Then that one would be very rigorous and really require a lot of redesign to be able to actually bring patients back in on time and accomplish those visits, which require monitoring and outreach.

Similar to that, I guess, the ones, for example, the persistent beta blocker treatment, number 23, after a heart attack, the current measures that I'm familiar with are did you get beta blockers prescribed after the heart attack? This … sort of up the ante by really requiring that there was persistent beta blocker treatment for six months after discharge, and it would require that kind of follow up. Is that what you mean when you talked earlier about workflow redesign?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes. Classic examples are number 27 and 28. Excellent evidence; everybody agrees it's a good idea. It's just incredibly hard to transact. Twenty percent is often the uptake after pretty focused efforts to get it done. And so, the concept is that with some of these, getting an LDL, basically you've just got to persuade the doctor to order it, and it pretty much happens. But something like the chlamydia is way more than that.

One way to think of it is what percent of the variation in performance could be attributed to HIT? Some things, it's just a matter of reminding a nurse or the doctor, a case manager, a patient, and it pretty much gets done. We send reminders for flu vaccines direct to patients, give them a number to call to sign up for a flu clinic and get tremendous results, where there are other things that that reminder or prompt or whatever it is just is only a very, very small part of getting something done. But the ones you mentioned are right.

I think the chlamydia is one that just everybody bangs their head against the wall. And it's just smart to be aware of that because if you say invite women 16 to 20 to have chlamydia or order chlamydia screening or something like that, that's much more in … control, whereas getting it done. I mean, I personally believe that that will become a quality measure, but it will be ten years from now when we're much better at patient education being pushed out through mobile phones and all the kinds of things that we're starting to do that, in ten years, we'll be pretty good at doing that sort of support that kind of recommendation that requires a lot of support.

Janet Corrigan – National Quality Forum – President & CEO
Okay.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
The Beers Criteria of Medicines are another classic example. It's trivial from a technology standpoint to identify patients that are on Beers Meds over 65. It's unbelievably hard to help patients move off those meds. And I'm sure you know that the issue here is that, well, from a Geisinger standpoint, one of the ways we try to address is say, "Look. Let's do the things first that are amenable to change while we're getting better and better at all the process stuff that goes around the more difficult stuff," and get buy in from clinicians.

See, one of the things, if you provide clinicians a reminder, and they look at it and say that's doable. There's good evidence. How could I possibly complain? I'm just grateful they're helping me get it done. And get them bought in at that level. Then when we start trying to do the trickier stuff, it's that same old thing. People are bought in. People understand the power of it. And people are used to the idea that we've invented all kinds of ways to do it besides just making them yell harder at the patient.

John Derr – Golden Living LLC – Chief Technology Strategic Officer

This is John again. Jim brings up really good thing on the Beers because that's one of the areas we have a real hard time getting people off the Beers because sometimes when we approach the clinician, they'll say, "Well, that person has been on it for years, and now I'm not going to take them off." And then that quality measure gets, you know, we get hit with that. And I think, once we get all this thing in harmony, then we can justify getting people off the Beers pharmaceuticals.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
See, that's just from a process. As the doctor, I'm very committed to getting my patients off Beers meds, and it's almost always patients that I've inherited that are on it, and they've always been on it for years. What invariably, really, 90% of the time it's a patient that you know. You don't try to do it at the beginning because you've got to know them. They've got to trust you. Then, at some point, when you feel you've got that kind of trust, you say, "You know, this kind of medicine may have been good for you 20 years ago, but as you get older, it's more and more dangerous," and blah blah blah. I recommend we try something else or see if you just don't need it sometimes.

They're unbelievably resistant to change. Very often, we'll go through four or five alternative medicines. And every time they come back and say, I'm dying. You're killing me, blah blah blah. Sometimes I get them off. But very often I just end up writing a note and saying I've explained this to them carefully. We've tried this and this and this and this, and they believe that symptomatically they just cannot function without this medicine, and so having explained the risks to them, I'm going to keep them on the medicine.

And so, it's hard for the doc, and it's hard for the docs, and of course the long term care facility is not going to get any movement on it. Some of them, we just have to be aware that they're like that, and it doesn't mean we dodge them, but it means we'll have to get better at supporting people with risk communication and cognitive behavioral therapy that can be delivered in little bits on mobile phones and those sorts of things that will make the hard ones doable.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Yes, and then we can get off paper.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes.

Janet Corrigan – National Quality Forum – President & CEO
Yes. Well then is the strategy for 2013, it really is that first category of measures where the percent of variation that is attributable to HIT is very high. I mean, if we hit those in 2013, and then those would require the process redesign probably would be more likely for 2015 and beyond.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think that would be a way to get people on and sort of ratchet this as time goes on. Yes.

Janet Corrigan – National Quality Forum – President & CEO
Yes, and … positive improvement that comes from acquisition of the technology and in just using it properly.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
And that's the other thing from the standpoint of people who have to justify this to their constituents, congress people, HHS, other people. If we do the ones first that we can be pretty confident we will get movement, then we can celebrate small victories, and that will be very important moving this thing down the road.

Janet Corrigan – National Quality Forum – President & CEO
Yes. Not to put you on the spot then, but looking at this list, we just talked about the ones that require the process redesign. What are the ones on this list that, 50%, 60%, 70% of the variation is attributable to HIT? Are there ones that jump out at you in that category?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes. Certainly anything that just requires testing, the lead testing, for instance, those are prone to be the ones where our reminder is the most powerful, and many organizations are probably already to the point that they semi-automate that stuff anyway. But it's hard to semi-automate them without HIT.

Taking hemoglobin A1c. When a patient and a doctor negotiate a care plan, and they agree that they're going to check hemoglobin A1c however often it is, then that's just built into the system, and the patient gets automatic reminders, and lots of patients get the reminder, come in and get it done. It comes in the doctor's in basket. They fix a note to the e-mail to the patient and say great work or we need to work on this, an blah blah blah and then it just runs. So those are the ones that immunization vaccines; as long as we have the patient or the parent defers as a qualifier, vaccinations are in that category. Most people agree they're a good idea. Certainly all clinicians do and so any of those would make sense.

The lipid screening, number one, I think one of the things that we probably ought to memorialize in the full committee is the principles would be my guess. I believe that pretty strongly would be to say we don't want to get out in front of the evidence. We just had two more big embarrassments where we'd been trying to push patients with diabetes, get their hemoglobin A1c below seven. Come to get a study that shows that's actually bad for people, and the high glucose control and ICU is the same kind of story. So I think that's one thing we want to be very rigorous, particularly again the first few years but really going forward.

I think HHS ought to really be careful that all the things that it measures and incentivizes, there really is excellent evidence for. As you know, there's plenty of that stuff. It's not like we'll run out of things to do in the next five years, if that's one of our standards. And so one of the things we'll want to watch, and I noticed a couple places in here, and you would see the same thing when we give you ours. Some of them represent organizational commitments; probably represent strong feelings of powerful leaders. I don't think there's any evidence about the number of well child visits for one thing, just as an example.

Now there will be times that we will say, okay, there's no evidence, but it's so deeply entrenched, maybe mammogram is a reasonable example of that that we're not going to mess with that. We'll still put it in as if there was evidence. But certainly, I think the well child visits; if we had anything, I think that would be a hard one to get enough consensus that it would have high face validity for everybody. And so that's one of the things to identify is the things that are not idiosyncratic in a bad way. I mean, what we'll find is these leading organizations will all be pushing the boundaries on things, but it'll just be far enough from the center that we don't want to include it in any early way in the measures.

Janet Corrigan – National Quality Forum – President & CEO
Yes, and that's the importance of realizing the limitations of this process that it's to identify the potential measure concepts. These measures still would have to come in and be vetted and evaluated for endorsement purposes by expert panels, which requires a review of the underlying evidence and rating the evidence and all of those good things to make sure that you don't have measures that may be very appropriate for quality improvement where there's a degree of judgment or a great deal of judgment that's exercised perhaps in application of particular patients. But as you begin to move towards those

standardized ones for your public reporting and meaningful use tied to it, you really need to be extremely careful. I agree with you 100%. It's very important.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes. I don't know. It might be that we want to ask these groups as an option because we don't want to keep them from doing it because we make it too much work. But we might say, if you would like to, we'd appreciate you listing the evidence you base this on, the guideline or the randomized trial or whatever. And that's a judgment call. That might make it enough work that people would just blow us off, so I offer that just as a thought.

Janet Corrigan – National Quality Forum – President & CEO
All right. Very good. Are there other comments about the approach or the list of groups or questions we should be asking, or have we pretty much covered it here?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
If you would like to hear some of the other comments, I got them late yesterday, so they're not on the slides, but some other kinds of measures that came up. But I think we've dealt with pretty much the issues of what needs to be evaluated is what can be handled primarily through electronic means or what can be improved with electronic sources and electronic records and what takes workflow. I think that's a great way to put this. Do you want to hear any of the others, or we'll just go ahead and collect from the various organizations?

Janet Corrigan – National Quality Forum – President & CEO
I think we can probably go ahead and collect them and summarize all the results, and sort of see where we're at at that point. In terms of the next steps, we'll go ahead and send the requests to the organizations that we've identified, and then we would need to compile. We'll want to share the results with certainly ONC obviously in the standards committee. This is something too, I think we need to make sure we stay in synch with the policy committee … perhaps want to get their input into this process as well, and make sure they know the direction that we're going because it may shape the types of measures that they identify that they would like us to then try to focus on for 2013. We kind of have two parallel processes going on. Given the time constraints, we have to just work in parallel. But I think, if we have a lot of transparency and communication, that will turn out to be okay, I would hope.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
I think you're right. Yes. By the way, if we could create a very simple, little spreadsheet that we sent to people, I think it would save Floyd and the other people who have to process this a fair amount of time because it'd be clear to people which bucket to put it in, and it might be easier to analyze.

Janet Corrigan – National Quality Forum – President & CEO
Great idea.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
And I would suggest high, medium, low, just three levels. Enough to let them help us filter this stuff, but not enough that they have to – well, that's just all the distinctions that can usually be meaningfully made about this stuff.

Janet Corrigan – National Quality Forum – President & CEO
Okay. That would be very helpful. Then once we've analyzed this and shared it, we'll hopefully be able to identify a subset of potential measures. Then we have to lay out the process for seeing if the measure stewards, whether those are the vendors or the health systems, are willing to bring those measures

forward, have them subject to rigorous evaluation, and potential candidates for endorsement, and then I think there's additional work that will be required to do the retooling of those measures because that has to be done consistent with the quality data set elements.

Floyd, you might want to update the group on where we're at in terms of the retooling of the 110 measures or so in the NPRM.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Sure. I can do that. We have now, with the original measure stewards, delivered 42 of the 110 measures in a spreadsheet format. They are not currently yet in the e-measure HQNF format, but that's the next step. But the first step was identifying all the QDS elements, making sure that the logic is properly identified now that they've been reconfigured for getting the information out of EHRs. We are in the process of working on the rest of them, but so far in the past, it's taken about three months to get these 42 done. We think that was rather aggressive, and our timeline is fairly aggressive to get the rest done as well.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
That's great. Good work.

Janet Corrigan – National Quality Forum – President & CEO
And these initial measures … the vast majority are owned by NCQA or the AMA, so they're doing all of this retooling, but Floyd and his staff are working very, very closely with the whole team because this is really the first time … all of this, and it's, in many ways, testing the quality data set and the underlying requirements and guidelines for doing this work in a very consistent and thorough way, so it's been quite a learning process.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
One of the things that's a little challenging is we have worked with basically two measure stewards to get these 42 done, and the learning process has brought us quite far. But there are an additional 14 measure developers that we have to work with, and this is a good thing, but each one is – we go through … I've given it the term axioms of really thinking about the intent of each portion of the measure: the denominator, the population, the numerator exclusions, and thinking about that same concept in an EHR concept rather than claims. And that does take a lot of – it's a big paradigm shift for folks.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Absolutely. What is your sense, Floyd, of how they are responding to the need for clinically meaningful and thorough going exclusion criteria?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Well, exclusions are an interesting area always in these discussions. Many of the measures that we've looked at so far allow a clinician, a physician to say I have a medical reason. It's not specified anywhere, but I know a reason, and they allow that. What the retooling has done is rather than a measure saying to a physician, and I'll use physicians here, but this could easily apply to a measure for any provider, here are the things to think about that are exclusions, and there are some others as well. So then you just put medical reason.

The retooling for everything that the measure currently says, if this diagnosis is present, if the patient has had this procedure in the past, each of those, rather than being in the general medical exclusion box, are identified as data elements. That specific condition or diagnosis might be an exclusion in one measure and inclusion in another.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Right.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
And so each of those was identified as the data element. That's a concept that has taken some time to kind of work through, and for us to find a way to state it and educate on it, and I'm talking about all of the measure development community, so that it's clear that each known reason for exclusion because it could be potentially identified electronically, is in the record, is a separate element. The question of whether one allows a non-specified patient reason or a non-specified medical reason is a different question. We're providing a method to do it because that's what the existing measures had. But we're trying to identify each thing that is the exclusion as a separate element. Does that help answer?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes. That's wonderful. Obviously, as these systems evolve, and to some extent now, it will improve adherence enormously to be able to filter out noise.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Yes, and the real intent of that is, it's one thing on a measure, and if we're thinking more toward outcomes, the exclusions may actually be less significant. But if we're thinking about clinical decision support, the exclusions create or really decrease noise significantly.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
So they are important to define.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes, so that's great. My view, for what it's worth, would be that we ought to keep the general. One of the rules about pick lists like that is that if you say other, please specify, sometimes what you pick up are things that should be on the pick list that you just hadn't realized. And so you can make those lists self-healing, besides which there's no possibility we can list all the reasonable reasons someone might not do something.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Right. So one of the challenges in doing that is how to capture and send and use on the receiver of the measure report, any of the free text of the other reasons. And that's something we do need to figure out. At the moment, we're using a list of medical reasons that's a bit more generic. There's actually in HL-7 in messaging a way to say reasons for not doing something, and we split those into patient reasons for not doing medical and system to fit the QDFs. But they don't specifically allow you to put a few words in to say why, so that's something we'd have to look at.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
You know, not for 2013. I mean, the second phase, once the dust settles on this, and we're trying to create the future systems. I think organizations like ours, I think many organizations would be able and willing to automate sending a flat file of free text content of those fields, or at least might be. We're talking with people that have to be suitably de-identified and all that. And that might give a lot of information no one would have the resources to analyze. But I think, at least providing that organization would be something that many of us could do relatively easily, and we'd be willing to do, just so it's in your mind.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Sure. Common reasons provided that aren't otherwise specified, I could see where that could be very helpful.

Janet Corrigan – National Quality Forum – President & CEO
Yes, very helpful to the stewards to coordinate that kind of effort for the whole group. Yes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Yes. And that will give them more reason to be happy to participate in this harmonization if they get something out of it.

Janet Corrigan – National Quality Forum – President & CEO
Yes. Good point. Good point. Okay. Well, I think we have our next steps here, and we've covered quite a bit of territory. We have a meeting of the standards committee next week. We'll provide them with an update, and we will, in the meantime, get the spreadsheets laid out in the request and get that out to the group. Hopefully be able to have some results in the not too distant future here. Judy, do you want to open it up for public comment?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. Thanks, Janet. Operator, can you see if anybody from the public cares to make a comment? Thank you. Floyd, if you want to work with me, I can make sure you get everybody's contact e-mail information, etc.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Great. That'll help.

Janet Corrigan – National Quality Forum – President & CEO
Then Judy will also figure out how we can, once this comes in, if we give people a couple weeks to respond, that's probably adequate. We'll analyze it, and be able to then get it up on the Web site for some public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
That's right. We'll figure all that out.

Janet Corrigan – National Quality Forum – President & CEO
Great.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, any comments?

Operator
We do not have any public comments.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Janet, good call.

Janet Corrigan – National Quality Forum – President & CEO
Wonderful. Thanks, everybody.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Have a good day.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant
Thank you.

Public Comment Received During the Meeting

1. How soon can we expect to see the 42 retooled measures made public?